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Corresponding Difficulty for the Elderly with Mental Cognitive Impairments and Effect of Educational Programs for Caregivers

（精神認知機能に問題のある高齢者
への対応困難な問題と対処教育プロ
グラムの効果）

原田 小夜

Original research

Title:

Effect of Education Programs for Caregivers with the Provision of the Elderly with Mental
and Cognitive Impairments

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Abstract

Authors provided education programs for certified caregivers to cope with elderly care recipients' behaviors caused by mental and cognitive impairments. Thirty-three participants enrolled in all of the programs consisting of lectures and case studies about the features of mental and cognitive functions among elderly people. Authors administered self-rating questionnaires about "feeling care difficulties" three times as follows: before and after the basic training, and after the follow-up training. Authors used Friedman's Test and Bonferroni multiple comparison of analyses for levels of difficulties. The levels of items for 'understanding mental symptoms and anxiety', 'communication skills' and 'dealt with life disabilities' were reduced significantly. The participants could better deal with care recipients because they understood the factors causing their behaviors. However, authors should clearly teach how to deal with behaviors such as silence. Furthermore, medical staff with mental patients should actively collaborate with certified caregivers to deal with deviant behavior.

Key Words: Aged, Caregiver, Education, Mental disorders

Introduction

Japan is a rapidly aging society. The morbidity rate of dementia in people over 65 years has reached over 14% (Shimokata, 2004), and the coping skills of certified caregivers who have provided the majority of care to those with behavioral and psychological symptoms of dementia (BPSD) are insufficient. Meanwhile, depression and anxiety patients consult psychiatric clinics frequently (Saito, 2009). The morbidity rate of mental and cognitive impairment in people over 65 years old who were provided with primary care was 48.1% (Watts, Bhutani, Stout Ducker, Cleator & McGarry, 2002), and 10% of elderly people had anxiety, while the rate of anxiety coexisting with depression was high (Flint, 1994). Moreover, previous studies reported that the rates of depression, agitation and psychotic symptoms in Alzheimer's disease in home care patients were 80%, 80%, 70%, respectively (Tractenberg, Weiner, Patterson, Teri L & Thal J, 2003). The number of elderly people with mental and cognitive impairments due to a decline in physical and mental functions with aging is increasing. Issues regarding general physicians' skills to diagnose depression and prescribe medication were reported (Meller et al., 2008a; Nakano et al., 2011) and it is necessary to construct a system of consultation by psychiatrists about residents' mental problems in institutions for the elderly (Pierre et al., 2008).

Long-term care insurance was introduced in 2000 in Japan to improve the care of elderly people with mental disorders, and care workers who are not mental health care specialists have provided the majority of care. In 2013, education for dementia care was included in the training programs of first grade caregivers, but a large number of certified caregivers providing care at present are home helpers (HH) second grade. They received education in a short period to get the license and did not study dementia.

Authors investigated HH regarding the actual care of elderly people with mental disorders, and found that HH could not consult any medical professionals if they had trouble, and that they were experiencing problems (Harada & Yamane, 2013a). HH understood the need for collaboration with mental health care medical staff to cope with emergency correspondence regarding suicidal ideation and sexual behaviors, but HH did not consult them about dealing with hallucinations, delusions and hypochondria that HH experience in daily care, even if they experienced difficulties because they thought that the difficulties in dealing with symptoms were caused by their lack of knowledge about the features of mental and cognitive functions among elderly people. Therefore, the education for certified caregivers is necessary (Harada, 2013).

Important research indicated that a comprehensive behavior-management-skills

training program for certified nursing assistants who provide care for cognitively impaired nursing home residents reduced the residents' agitation levels (Burgio & Stevens et al., 2009; Philip & Ronald, 1999). As for depression, some previous research reported that skills for dealing with people with depression increased among care workers who attended depression training programs (Mellor & Davison et al., 2008a; Mellor & Russo et al., 2008b; Mellor & Kishne et al., 2010). The fundamental position of Japan's Ministry of Health, Labour and Welfare indicated training systems and programs for dementia patients in 2012, and promoted care skills for dementia patients for certified caregivers; however, there is little research evidence about the programs.

Therefore, authors framed and implemented programs for certified caregivers that provide care services for elderly people with mental and cognitive impairments. The purpose of this study was to clarify the effects and durability of these effects, and examine issues involved when teaching care skills to certified caregivers.

Methods

Participants

The participants in this study were certified caregivers working in long-term care insurance community care offices in an area with a population of 320,000 and a 17.9% elderly population. Authors explained the purpose of this study to the managers of 12 home care offices to whom the authors was introduced by community comprehensive service centers or home visit nursing stations. Authors recruited over 50 participants, but home care offices were small, and there were a few offices that had meetings among certified caregivers. Finally, 2 offices consented to our proposal. There were 14 people working in the home visiting care offices linked to home visit nursing stations offices and 19 people working in home visit care and day service care offices linked to group homes for people with dementia. Both offices were managed by a social welfare corporation and the managers of the offices were professional care workers who provided care to elderly people with mental disorders and dementia.

Interventions

The program looked at the way in which participants grappled with studying actively and consisted of lectures about the features of mental and cognitive functions among elderly people and case studies for dealing with elderly people with mental and cognitive impairments (Hotta, 2012; Yamane, 1994; Takenaka, 2000; Japan Dementia Communication Conference, 2011). The basic program was done twice. The first time,

authors provided a lecture about the behaviors of elderly people with mental and cognitive impairments, and the contents were based on previous research in which home care recipients were perceived by certified caregivers as creating difficulties in terms of care and coping. In the programs, participants studied a procedure for considering why care recipients behaved.

After 1-2 months, authors provided a second program with a review of the first lecture and case studies were provided by participants. The program lasted one to one and half hours, and authors provided it three times; two groups consisted of 7 members and one group consisted of 19 members. After 6 months, authors provided a follow-up program with a review of the basic program. In particular, communication skills and case studies were provided by participants. The program was carried out from August 2012 to March 2013 (Figure 1).

Ethical concerns

Authors obtained approval from the participants after explaining that they would participate in this study of their own free will, that the records would be kept safely, and that they would not be used outside the auspices of this study in either oral or written form. The study protocol was approved by the Medical Ethics Committee at Kyoto University.

Data collection

Authors administered self-rating questionnaires survey to participants three times as follows: before and after the basic training and after the follow-up training. Authors distributed and collected the self-rating questionnaires to participants directly at the time of training. Authors asked participants to write code numbers for personal identification so they could identify who wrote questionnaires and analyze the difference between before and after the basic training and after the follow-up training. The self-rating questionnaires asked about participant's attributes and "feeling care difficulties". Authors collected data of participant's attribute regarding age, sex, number of experiences of care for recipients with mental and cognitive function disorders: schizophrenia, depression, home care or day service in the first questionnaire before the basic training. Authors collected data regarding "feeling care difficulties" before and after the basic training and after the follow-up training, as well as data regarding impressions about the programs, and a free description after the programs regarding experiences of "feeling care difficulties" before the basic training and the follow-up training. There were 24 items about "feeling care difficulties" grouped as follows: dealing with psychiatric symptoms, depression, anxiety, refusal and aggression,

communication skills, and dealing with cognitive impairments, which authors referred to in previous research (Harada, 2013). The Likert scale of feeling care difficulties (*can handle with no feelings, can handle without feeling difficulties, can handle, but feel difficulties, and cannot handle and feel difficulties*) were assigned from levels 1–4, respectively.

Analysis

Authors analyzed the rates of the participants' characteristics, experiences and feeling of difficulty levels of the 24 items. Authors used Friedman's Test and Bonferroni multiple comparison of analyses to compare each pair with levels of difficulty as follows: before and after the basic training and after the follow-up training, and Mann-Whitney U test for the relations between experiences and feeling of difficulty levels. IBM SPSS Statistics (Statistical Package for Social Sciences v20 for Windows) was used for the statistical analyses, and the significance level was $p < 0.05$. Regarding feeling of difficulty, authors processed data excluding missing values for every feeling of difficulty level item.

Authors classified free descriptions into categories according to the contents of participants' comments on care and coping. In the following sections, double quotes and square brackets enclose categories and spoken contents, respectively.

Results

1. Characteristics and experiences of the participants' care

The participants comprised 2 male and 31 female individuals, and they were aged 46.8 ± 9.7 ; eight participants were regular workers employed full-time and twenty-five participants were part time workers. Their average number of years of experience as certified caregivers was 5.82 and the range was 1.2 to 13 years. Fourteen participants were professional care workers. The rates of participants who attended the training with dementia and mental disorders were 42.4% and 12.2%, respectively. The rates for giving care to patients with schizophrenia, depression, and others, were 15.5%, 33.3% and 21.1%, respectively (Table 1).

2. Participants' experience for items of care difficulties

Regarding having had experience of the 24 items, over 50% of items both before the basic training and before the follow-up training had been experienced by 54.5% and 66.7%, 78.8% and 63.6%, 66.7% and 57.6%, 57.6% and 57.6%, 78.8% and 66.7%, 66.7% and 54.5% (1, 2, 7, 10, 12 and 22, respectively). Over 50% of items before the

basic training or before the follow-up training were experienced at rates of 3, 15 and 17, respectively. Items at low rates were experienced at rates of 5, 8, 11, 19 and 24, respectively (Table 2).

3. The scores for feeling care difficulties (Table 3)

There were missing values before the basic training, so authors processed data excluding missing value every feeling of difficulty levels of items. Eighteen items' rates showed significant results between the score before the training and after the training.

The items' rates that showed significant results between the score before the training and after the basic training, and between the score before the training and after the follow-up training included 6 items as follows: 2, 7, 12, 17, 18, 22 and 24. The items before the basic training, after the basic training and after the follow-up training of items were experienced by $3.06 \pm .61$ to $2.24 \pm .61$ to $2.15 \pm .57$ ($\chi^2 = 25.47, p < .000$), $3.03 \pm .77$ to $2.13 \pm .82$ to $2.15 \pm .57$ ($\chi^2 = 16.69, p < .000$), $2.83 \pm .70$ to $1.97 \pm .62$ to $1.70 \pm .53$ ($\chi^2 = 28.23, p < .000$), $2.67 \pm .82$ to $1.87 \pm .68$ to $1.84 \pm .63$ ($\chi^2 = 15.39, p < .000$), $2.96 \pm .83$ to $2.26 \pm .83$ to $2.18 \pm .53$ ($\chi^2 = 15.57, p < .000$), $2.27 \pm .59$ to $1.93 \pm .46$ to $1.70 \pm .64$ ($\chi^2 = 26.44, p < .000$) and $3.16 \pm .83$ to $2.21 \pm .86$ to $1.97 \pm .65$ ($\chi^2 = 15.96, p < .000$), all of $df = 2$, with average scores of 2, 12, 17, 18, 22 and 24, respectively.

Items experienced with significant results only between the score before the training and after the follow-up training included 6 items as follows: 1, 10, 14, 15, 20, 21 and 23. The items' rates before the training and after the follow-up training were experienced by $2.54 \pm .51$ to $1.81 \pm .58$ ($\chi^2 = 14.83, p = .001$), $2.64 \pm .91$ to $1.76 \pm .50$ ($\chi^2 = 15.64, p = .001$), $3.12 \pm .90$ to $2.45 \pm .67$ ($\chi^2 = 7.80, p = .020$), $3.31 \pm .74$ to $2.28 \pm .63$ ($\chi^2 = 12.43, p = .002$), $2.77 \pm .87$ to $1.97 \pm .53$ ($\chi^2 = 13.35, p = .001$), $2.57 \pm .90$ to $1.96 \pm .71$ to $1.76 \pm .61$ ($\chi^2 = 12.16, p = .002$) and $2.65 \pm .88$ to $1.76 \pm .56$ ($\chi^2 = 11.31, p = .004$), all of $df = 2$, with average scores of 1, 10, 14, 15, 20 and 23, respectively. The score of 3 and 6 items experienced with significant results between the score before the training and after the basic training, but results of Bonferroni multiple comparison were not significantly, $3.03 \pm .77$ to $2.13 \pm .82$ to $2.15 \pm .57$ ($\chi^2 = 8.97, p = .011$) and $2.75 \pm .97$ to $1.95 \pm .76$ to $1.82 \pm .68$ ($\chi^2 = 9.52, p = .009$) all of $df = 2$, with average scores of 3 and 6, respectively. The score of 9 and 16 items experienced with significant results between the score before the training and after the basic training, but the score after the follow-up training deteriorated. Items were not significantly included 6 items as follows: 4, 5, 8, 11, 13 and 19.

The scores of 22 items after follow-up training showed significant differences between the participants who had experience before follow-up training and the

participants who had no experience, $1.91 \pm .725$, $1.40 \pm .27$, $z = -2.204$ ($p = .044$), with average scores of 22.

4. The contents of the free descriptions

There were 47 descriptions after the follow-up training. “how to deal with care recipients” was experienced by 14: [We should provide care service to respect care recipient’s feelings], “exchange information in the office” was experienced by 9: [It is important to have jointly with other staff care recipient’s behaviors which I felt difficulties to deal with], “multidisciplinary collaboration” was experienced by 10: [It is necessary to report and consult to the mental medical staff the difficulties of dealing with care recipient’s behaviors and request the medical judgment], [It is necessary to exchange opinions with other professional staff], and “impressions of this program” was experienced by 14: [I studied the case studies about cases with which the other staff deal with], [The way in which participants grappled with studying actively was good].

Discussion

In a comparison of “care difficulties” between before the training and after the basic and follow-up training, authors investigated the effects of this education program and other issues related to the education of certified caregivers.

1. Concerning the items for which the levels difficulty were reduced

Both after the basic and follow-up trainings, the average scores of the care items with respect to dealing with anxiety such as ‘fluctuations in care recipient’s mood’ and ‘symptoms of hypochondria’, ‘ignorance of social norms’, ‘insufficiency care time’ and ‘hurting the care recipient’s pride’ decreased. The participants could understand that care recipients’ anxieties were caused by the feeling of loss and loneliness elderly people experience; therefore, they could develop inner reserves and deal with care recipients with composure. Regarding ‘hurting the care recipient’s pride’, the scores of the participants who had care experience were significantly higher than those who had no experience. The authors assume that the participants felt confidence having experienced mistakes; therefore, it is desirable that certified caregivers have training as soon as possible after they are employed.

Furthermore, the care difficulties of care recipient’s regarding the rules of life caused differences in the values between certified caregivers and care recipients (Harada & Yamane, 2013). Authors included the experience of the care recipient feeling as if it had been the participants’ own in the program, so the certified caregivers could understand care recipient’s sense of values and thinking, and consider care recipient’s feelings. It is

easy for certified caregivers to understand care recipient's anxieties and the rules of life. The average scores of the care items with respect to 'hallucinations and delusions', 'the appropriate way to speak to care recipients', 'refusal of care that certified caregivers could not understand' and 'care recipient's violence' decreased. The care items with respect to understand psychiatric symptoms, the assessment of disabilities in life and communication skills were effects experienced after the follow-up training. If certified caregivers received acknowledgment and understand the recipient's mental disease, it is easy for them to deal with psychiatric symptoms and mental disabilities in practice. The participants should understand care recipient's communication disabilities and study them, then acquire communication skills to address this problem. In the implementation of case studies in this program, authors selected care recipient's behaviors which caused difficulties for participants in practice. Authors had shared differences with care recipient's responses, integrated our information and clarified how to deal with care recipient's behaviors which caused difficulties for participants. Consequently, the care difficulties for certified caregivers improved. The rate of experience of the items for which the levels difficulty were reduced was high, meaning certified caregivers have a lot of experience of care; consequently, they can make the most of their opportunities.

2. Concerning the items for which the levels difficulty deteriorated after the follow-up training

The average score of items 'care recipients not speaking and being silent' and 'care recipients cannot dump trash' deteriorated after the follow-up training. The certified caregivers have to finish care services after a limited length of time for care-plans under Long-term care insurance. Also, certified caregivers need to confirm care recipient's wishes in order to provide appropriate care services; they were sometimes hasty in reacting to care recipients' silence. The dissatisfaction with the behavior 'cannot dump trash' indicates the certified caregivers cannot clean rooms and provide the care services in the care-plan. Therefore, the authors assume that the participants thought they could deal with the care recipient's behaviors immediately after the basic program, but could not deal with them easily in practice. The follow-up programs supplemented the basic program to clarify the factors that caused the behavior and why the care recipients behaved in that way. Consequently, 'feeling care difficulty' about these items could not be easily reduced. Previous research reported that skills to clearly deal with BPSD were taught in communication skills training for nursing assistants for the care for dementia patients (Philip & Ronald, 1999; Burgio et al., 2009; Roque et al., 2009). Concerning care recipients 'not speaking and being silent' and 'care recipients cannot dump trash', it

is necessary to teach both awareness of the background factors and how to practically deal with these issues in practice.

3. Concerning items for which the difficulty level did not change before the training and after follow-up training

The difficulty level for deviant behaviors such as ‘sexual behaviors’ and ‘suicidal ideation’ were not improved. Thesis items were characterized as to whether certified caregivers could not resolve them. It is necessary that certified caregivers consult medical staff who deal with mental patients and help them cope in multidisciplinary collaboration. However, certified caregivers hesitate to consult medical staff who deal with mental patients and have issues about this (Harada & Yamane, 2013). Certified caregivers were undecided whether they should consult medical staff who deal with mental patients and worried that medical staff who deal with mental patients would not respond to their consultations. The item “multidisciplinary collaboration” was experienced as [It is necessary to report and consult medical staff who deal with mental patients about the difficulties in dealing with care recipient’s behaviors and request advice] in the free descriptions. The participants could understand that it is necessary to consult medical staffs who deal with mental patients about the care recipients’ behaviors with which they could not cope with through multidisciplinary collaboration and case studies. Medical staffs who deal with mental patients should collaborate with certified caregivers actively, and supply information about how to deal with care recipients’ deviant behaviors.

4. Limitations

This study consisted of examinations conducted in one area with a small number of participants, so the effects of this program are inconclusive. Authors could not set up a control group because authors could only select a few offices as the subjects of our research. Six participants left during the period of our research, so authors did not have many participants to confirm the durability of the effects of our education program. As a result, authors could not clarify the difference in distribution of the levels of difficulty by the participants’ characteristics such as age and number of experiences of care for recipients. Furthermore, authors examined the care difficulties for certified caregivers, but authors did not evaluate an index of outcome measures such as care recipient’s QOL (Quality of Life); therefore, the effects of this program has limited explanatory power. However, the programs provided by our research are consistent in the number of times, as well as the time required to fit in the working shifts of staff in home care offices, so other offices could easily introduce our program.

The staff in the offices to which authors provided the programs exchanged information after the program. Thus, the effects of our programs are ongoing. Furthermore, it is necessary to do future studies with more participants and examine the results quantitatively, as well as construct systems to implement education programs.

Conclusion

The following 3 points were effects and issues related to our programs:

- 1) The difficulty levels of the items 'understanding mental symptoms such as hallucinations, delusions, anxiety and hypochondria', 'understanding life skills such as ignorance of social norms' and 'communication skills such as the appropriate way to speak to care recipients' were reduced significantly.
- 2) Concerning the levels of items 'care recipients not speaking and being silent' and 'care recipients cannot dump trash', authors should teach caregivers how to deal with practically deal with them.
- 3) The levels of items for deviant behaviors were not effective. Medical staffs who deal with mental patients should collaborate with certified caregivers actively and deal with deviant behaviors through multidisciplinary collaboration.

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Table 1 Characteristics of the participants		N=33	
		n (%)	
Sex	Male	2	(6.1)
	Female	31	(94.9)
Employment	Regular worker	8	(24.2)
	Part time worker	25	(75.8)
License	Professional care worker	14	(42.4)
	Home helper	19	(57.6)
Attended the Training programs	Mental disorder	yes	4(12.1)
		no	29(87.9)
	Dementia	yes	14(42.4)
		no	19(57.6)
Care Experience	Schizophrenia	yes	5(15.2)
		no	28(84.8)
	Depression	yes	11(33.3)
		no	22(66.7)
	Other mental disease	yes	7(21.2)
		no	26(78.8)

EFFECT OF EDUCATION PROGRAMS FOR CAREGIVERS WITH THE PROVISION OF THE ELDERLY

Table 2 Participants' experience of difficulty with each item

N=33

	before basic training		before follow-up training	
	yes	no	yes	no
	n (%)	n (%)	n (%)	n (%)
1. Hallucinations and delusions	18(54.5)	15(44.5)	22(66.7)	11(33.3)
2. Fluctuations in care recipient's mood	26(78.8)	7(21.2)	21(63.6)	12(36.4)
3. Hallucinations in which someone steals	13(39.4)	20(60.6)	18(54.5)	15(45.5)
4. Sexual behaviors	7(21.2)	26(78.8)	8(24.2)	25(75.8)
5. Threatened by care recipients	4(12.1)	29(87.9)	0	33(100)
6. Causing care recipients anxiety about being dirty	11(33.3)	22(66.7)	10(30.3)	23(69.7)
7. Talking about suicide	22(66.7)	11(33.3)	19(57.6)	14(42.4)
8. Suicidal ideation	4(12.1)	29(87.9)	2(6.1)	31(93.9)
9. Care recipients not speaking and being silent	14(42.4)	19(57.6)	16(48.5)	17(51.5)
10. Mentioning anxiety about life	19(57.6)	14(42.4)	19(57.6)	14(42.4)
11. Many phone calls	2(6.1)	31(93.9)	2(6.1)	31(93.9)
12. Symptoms of hypochondria	26(78.8)	7(21.2)	22(66.7)	11(33.3)
13. Certified caregivers scolded by care recipients, but not understanding why	11(33.3)	22(66.7)	9(27.3)	24(72.7)
14. Care recipient's violence	15(45.5)	18(54.5)	10(30.3)	23(69.7)
15. Refusal of care that certified caregivers could not understand	20(60.6)	13(39.4)	14(42.4)	19(57.6)
16. Care recipients cannot dump trash	10(30.3)	23(69.7)	12(36.8)	21(63.2)
17. Ignorance of social norms	16(48.5)	17(51.5)	17(51.5)	16(48.5)
18. Insufficient care time	14(42.4)	19(57.6)	12(36.8)	21(63.2)
19. No sense of the value of money	3(9.1)	30(90.9)	5(15.2)	28(84.8)
20. Difficulties understanding life skills	16(48.5)	17(51.5)	6(18.2)	27(81.8)
21. How to maintain appropriate distance from care recipients	14(42.4)	19(57.6)	8(24.2)	25(75.8)
22. Hurting care recipient's pride	22(66.7)	11(33.3)	18(54.5)	15(45.5)
23. The appropriate way to speak to care recipients	14(42.4)	19(57.6)	7(21.2)	26(78.8)
24. Care recipients forget when certified caregivers will visit	8(24.2)	25(75.8)	5(15.2)	28(84.8)

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Table 3 The scores for items before and after the basic training and after the follow-up training

		Mean	SD	χ^2 -Score	<i>P</i> -value	multiple comparison <i>P</i> -value
1. Hallucinations and delusions (n=25)	before	2.54	.51	14.83	.001] **
	basic	2.00	.67			
	follow-up	1.81	.58			
2. Fluctuations in care recipient's mood (n=27)	before	3.06	.61	25.47	.000] **
	basic	2.24	.61			
	follow-up	2.15	.57			
3. Hallucinations in which someone steals (n=18)	before	2.91	.85	8.97	.011] **
	basic	2.17	.72			
	follow-up	2.00	.67			
4. Sexual behaviors (n=12)	before	2.27	1.07	3.50	.174] *
	basic	2.22	.88			
	follow-up	2.13	.66			
5. Threatened by care recipients (n=9)	before	3.00	1.34	2.14	.343] *
	basic	2.36	.92			
	follow-up	2.42	.61			
6. Causing care recipients anxiety about being dirty (n=16)	before	2.75	.97	9.52	.009] **
	basic	1.95	.76			
	follow-up	1.82	.68			
7. Talking about suicide (n=26)	before	3.03	.77	16.69	.000] **
	basic	2.13	.82			
	follow-up	2.15	.57			
8. Suicidal ideation (n=14)	before	3.07	1.28	4.48	.107] **
	basic	2.60	.28			
	follow-up	2.67	.65			
9. Care recipients not speaking and being silent (n=17)	before	2.86	.79	13.56	.001] **
	basic	1.86	.66			
	follow-up	2.10	.72			
10. Mentioning anxiety about life (n=21)	before	2.64	.91	15.64	.000] **
	basic	1.88	.53			
	follow-up	1.76	.50			
11. Many phone calls (n=12)	before	2.67	1.18	1.27	.529] **
	basic	2.20	.68			
	follow-up	2.06	.62			
12. Symptoms of hypochondria (n=24)	before	2.83	.70	28.23	.000] **
	basic	1.97	.62			
	follow-up	1.70	.53			

(continued)

EFFECT OF EDUCATION PROGRAMS FOR CAREGIVERS WITH THE PROVISION OF THE ELDERLY

		Mean	SD	χ^2	P-value	multiple comparison P-value
13. Certified caregivers scolded by care recipients, but not understanding why (n=16)	before	2.74	.93	1.27	.531	
	basic	2.26	.73			
	follow-up	2.33	.69			
14. Care recipient's violence (n=21)	before	3.12	.90	7.80	.020	**
	basic	2.71	.87			
	follow-up	2.45	.67			
15. Refusal of care that certified caregivers could not understand (n=20)	before	3.31	.74	12.43	.002	**
	basic	2.42	.81			
	follow-up	2.28	.63			
16. Care recipients cannot dump trash (n=17)	before	2.63	1.01	9.70	.008	*
	basic	1.68	.48			
	follow-up	1.81	.73			
17. Ignorance of social norms (n=21)	before	2.67	.82	15.39	.000	**
	basic	1.87	.68			
	follow-up	1.84	.63			
18. Insufficient care time (n=20)	before	2.96	.83	15.57	.000	**
	basic	2.26	.73			
	follow-up	2.18	.53			
19. No sense of the value of money (n=10)	before	2.54	1.13	.55	.761	
	basic	2.31	.63			
	follow-up	2.03	.54			
20. Difficulties understanding life skills (n=19)	before	2.77	.87	13.35	.001	**
	basic	2.23	.61			
	follow-up	1.97	.53			
21. How to maintain appropriate distance from care recipients (n=18)	before	2.57	.90	12.16	.002	**
	basic	1.96	.71			
	follow-up	1.76	.61			
22. Hurting the care recipient's pride (n=25)	before	2.72	.59	26.44	.000	**
	basic	1.93	.46			
	follow-up	1.70	.64			
23. The appropriate way to speak to care recipients (n=17)	before	2.65	.88	11.31	.004	**
	basic	2.05	.61			
	follow-up	1.76	.56			
24. Care recipients forget when certified caregivers will visit (n=16)	before	3.16	.83	15.96	.000	**
	basic	2.21	.86			
	follow-up	1.97	.65			

before: before the basic training; basic: after the basic training; follow-up: after the follow-up training

The Likert scale of feeling care difficulties (can handle with no feelings, can handle without feeling difficulties, can handle, but feel difficulties, and cannot handle and feel difficulties) were assigned from levels 1–4

Friedman's test, df=2, Bonferroni multiple comparison : significant at **p<.01, *p<.05

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Session	The aim of the program	The study contents
The basic program the first time (Lecture) 	Understanding the characteristics of elderly people with mental and cognitive impairments	<ul style="list-style-type: none"> •Confirmation of the program rules •Taking an active part in the programs, analyzing cases that the participants found difficult, and guaranteeing freedom of speech and ideas •Studying elderly people's environments by talking about their experiences of loss, isolation and solitude, and personality changes •Studying the peculiarities of mental symptoms in the elderly such as hallucinations, delusions and anxieties •Considering tactics to deal with care recipients •Considering the reasons for care recipients' silence and ignorance of social norms
1 to 2 months later the second time (Brief lecture and case study) 	Focusing on communication skills and collaboration with medical staff on case studies	<ul style="list-style-type: none"> •Confirmation of the program rules •Considering why caregivers could not develop a good relationship with the care recipients •Considering the recipient's point of view •Understanding elderly people with schizophrenia •Considering the meaning of care recipients talking about suicide •Case studies about dealing with care recipients who could not limit their drinking or eating and those who are focused on social norms
6 months later the follow-up program (Lecture and case studies)	Focusing on communication skills and collaboration with medical staff on case studies	<ul style="list-style-type: none"> •Confirmation the rules of the programs •Considering why caregivers could not develop a good relationship with the care recipients •Considering the recipient's point of view •Understanding communication disorders in dementia •Case studies about dealing with care recipients' refusals, aggression and agitation

Figure 1 Overview of the education program contents

[Original article]

Care Recipients' Behaviors that Make it Difficult for Home Helpers to Cope with the Provision of Home Care for Elderly People with Mental Disorders

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I implemented an interview to investigate which behaviors of elderly people with mental disorders who were care recipients of home care were perceived by home helpers (HH) as creating difficulties in care and coping. I elicited care recipients' behaviors that HH felt created care difficulties, and classified them into categories. I classified coping among HH into 4 levels : *could not treat at all*, *could not treat*, *could treat*, and *could treat well* and these were assigned as levels 1-4, respectively. Further, I measured the rates of each coping level among HH according to categories and subcategories of care recipients' behaviors. The care recipients' behaviors that caused HH to feel care difficulties were numerous (151 responses) ; I divided these responses into 7 categories and 18 subcategories. The 7 categories were as follows : 51 responses were categorized as "deal with psychiatric symptoms," 5 responses as "deal with depression," 12 responses as "deal with anxiety," 17 responses as "deal with refusal and aggression," 36 responses as "deal with life disabilities," 23 responses as "communication techniques," and 7 responses as "action in cases of cognitive impairment." The extent to which HH effectively coped with these responses was evaluated as level 1, 2, 3, and 4 (47 responses [31.1%], 44 responses [29.1%], 33 responses [21.9%], 27 responses [17.9%] and respectively). The coping levels with "deal with psychiatric symptoms," "deal with depression," and "deal with refusal and aggression" were low, and the levels of "deal with anxiety" and "action in cases of cognitive impairment" were high. The levels of "deal with life disabilities" and "communication techniques" were different in each subcategory. For HH to ameliorate care difficulties, it is important to promote training programs to improve the knowledge and comprehension of psychiatric symptoms and disabilities and to construct systems by which they can consult medical staff in case of trouble. In addition, a multidisciplinary team should receive joint information from HH on care recipients, which it can then utilize to monitor care recipients' problems.

Key Words : Elderly people, mental disorders, home helper, coping, difficulties of care

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Introduction

Since the inception of *The Vision of the Innovation of Mental Health and Welfare*¹⁾ in 2004, it has been the fundamental position of Japan's Ministry of Health, Labour and Welfare that "community care has been centered on hospitalization, not in the community." In response, the system of mental and medical health and welfare was reorganized to advance the preparation of a community foundation for elderly care. In 2006, a law providing support for the independence of disabled people was enacted and the venues for dealing with mental disorders changed from mental hospitals to the community. The shift to community care for the management of mental disorders in Japan was supported so that the number of inpatient beds in mental hospitals could be reduced. Consequently, mental hospitals and related facilities have been at the core of home care services, and the staff of community support centers have provided care services in the community. Mental health care specialists have been at the center of team care.

Long-term care insurance was introduced in 2000 to improve the care of elderly people with mental disorders, and care workers who are not mental health care specialists have provided the majority of care. Care managers who perceived that elderly people with mental disorders were difficult to support required multidisciplinary collaboration within the support team. This indicated a problem of the absence of collaboration between care workers and psychiatric care providers²⁾.

Care for mental disorders in adults by home care workers began in 2002. It has been difficult for home helpers (HH) to understand mental disease and there have been gaps between care recipients and HH in terms of care in failing areas, while the behaviors of HH have caused confusion among care recipients^{3,4)}. However, HH have responded flexibly, and changes in recognition and behavior between HH and care recipients have occurred. Some studies described the peculiarities and difficulties of mental disorders among elderly people^{5,6)}.

The effects of mental and medical services on England's National Service Framework for Older People (NSFOP)⁷⁾ have been shown in recent studies

regarding care for elderly people with mental disorders, and the inspection for Assertive Community for Dealing with Elderly People (ACTE) in the Netherlands has been implemented to prevent elderly people with mental disorders from dropping out of psychiatric care⁸⁾. Studies on care workers who deal with elderly people with mental disorders have been conducted in nursing homes. Burgio and colleagues reported that a comprehensive behavior-management-skills training program for certified nursing assistants who provide care for cognitively impaired nursing home residents reduced the residents' agitation levels⁹⁾. David and colleagues successfully implemented depression training programs and skills for dealing with people with depression increased among care workers who attended their programs^{10,11)}.

There have been few reports on the switchover from care in medical facilities to community care for elderly people with mental disorders in Japan. Furthermore, the difficulties felt by care workers in the provision of care have not been clarified. Thus, the purpose of this study was to clarify the behaviors that lead HH to feel difficulties in terms of coping with the provision of home care to elderly people with mental disorders.

Methods

Participants

The participants in this study were HH who had more than 3 years of experience as HH and provided care to elderly people with mental disorders under the aegis of home visiting care offices in four cities in Japan's Shiga Prefecture. I explained the purpose of this study to the managers of home visiting care offices, to whom I was introduced by community comprehensive service centers or home visiting nursing stations, and they each recommended 1-2 participants in their respective offices. I adopted 20 HH with their consent, and confirmed theoretical saturation (**Table 1**). They comprised 1 male and 19 female individuals, and their age distribution was as follows : 1, 2, 7, 6, and 4 participants were aged 21-30, 31-40, 41-50, 51-60, and 61-70 years, respectively. The distribution of number of years' experience as an HH was as follows : 5, 4, and 10 participants had <5, 5-10, and >10 years of experience, respectively. Fourteen participants were

Table 1 Participant characteristics

no	1	2	3	4	5	6	7	8	9	10
Offices	A	B	B	C	C	D	D	E	E	F
sex	female	female	female	female	female	female	female	female	female	female
age (decade of life)	50	60	60	50	40	50	40	50	40	40
licenses	HH first class professional care worker	HH second class	HH first class professional care worker care manager, dietitian	HH second class	HH first class	HH second class professional care worker	HH second class professional care worker	HH second class professional care worker	HH second class managing HH	HH second class professional care worker
experience of duties (years)	13	16	15	10	3	8	8	11	9	4
case characteristics : age (decade of life), sex, diagnosis, living situation	80, female, depressed state with hallucinations, with family	80, female, manic- depression, alone	80, female, paranoia, alone	60, male, schizophrenia, alone 60, female, schizophrenia, living with family	60, male, schizophrenia, alone 60, female, schizophrenia, living with family	70, female, manic- depression, living with family 80, female, autonomic imbalance, alone	70, female, manic- depression, living with family 80, female, autonomic imbalance, alone	70, male, schizophrenia, alone	70, male, schizophrenia, alone	70, male, schizophrenia, alone 80, female, paranoia, alone
conditions of employment	regular, adminis- trator	regular, manager of services	regular, manager of services	regular	regular, manager of services	regular, manager of services	regular, manager of services	regular, manager of services	regular	regular, manager of services
no	11	12	13	14	15	16	17	18	19	20
Offices	F	G	H	H	I	I	J	K	K	L
sex	female	female	female	female	female	female	female	female	male	female
age (decade of life)	20	50	40	60	40	50	60	30	40	30
licenses	HH second class	HH first class professional care worker	HH second class professional care worker	HH second class professional care worker	HH second class professional care worker	HH first class professional care worker	HH second class professional care worker	HH first class professional care worker dietitian	HH first class professional care worker	professional care worker
experience of duties (years)	4	15	10	14	3	5	10	3	4	10
case characteristics : age (decade of life), sex, diagnosis, living situation	70, male, schizophrenia, alone	60, male, schizophrenia, alone 80, female, schizophrenia, alone 80, female, depressed state with delusions, with family	80, male, schizophrenia, alone	80, male, schizophrenia, alone	70, male, depression, alone	70, male, depression, alone 70, female, anxiety, with family 70, female, manic- depression, alone	70, male, schizophrenia, alone 70, female, schizophrenia, alone	70, male, depression, alone 70, female, Parkinson's disease with hallucinations and delusions, with family	70, male, depression, alone	70, female, depression, alone 70, female, paranoia, alone
conditions of employment	regular	regular, administrator	regular	regular, administrator	regular	regular, manager of services	regular, manager of services	regular, administrator	regular	regular, manager of services

professional care workers. They had each provided care to 1-2 elderly people with mental disorders and their conditions included schizophrenia, paranoia, depression, and autonomic imbalance, while some clients had unclear diagnoses.

Data collection

I did semi-structured interviews of HH from September to December 2011. The interview theme was, "Concerning the elderly people with mental disorders you care for, what difficulties have you felt in catering to their behaviors, how did you respond, and what were the reasons for your feelings?"

Each interview lasted about 40 minutes and the interviews were recorded with the each participant's approval.

Analysis

I prepared verbatim interview records and performed content analysis on the responses of the HH. I elicited descriptions of care recipients' behaviors that caused HH to feel difficulties in terms of care and descriptions of the coping techniques employed by HH to deal with these. I classified these behaviors into categories according to the contents of care recipients' behaviors.

I classified the coping effectiveness of HH into 4 levels : *could not treat at all*, *could not treat*, *could treat*, and *could treat well* were assigned levels 1-4, respectively. Categorization was performed according to the descriptions of HH regarding their reasons for, and feelings after, each behavior. The definitions of the numbered coping levels were as follows : level 4 signified that the HH improved or settled the difficulties with care recipients' behaviors, level 3 signifies that HH were not bothered and continued to care for the recipients, level 2 signifies that HH were uncertain and bothered about the continued provision of care, and level 1 signified that HH were greatly perplexed about how to treat care recipients. I measured the ratios of coping levels in each category and subcategory of care recipients' behaviors with which HH felt care difficulties. Further, I examined the relevant distinctions between care recipients' behaviors that led HH to feel difficulties in terms of care and coping. In this study, I did not analyze the difference in distribution of the coping levels by the participants' characteristics. I examined enough kinds of care recipients' behaviors

that caused HH to feel difficulties regarding care, and as a result some behaviors appeared once or twice. I asked a scientist who was well informed about qualitative research about classification of the behaviors, decisions regarding the coping levels and investigation of the validity to improve the strictness level of this study. In the following sections, double quotes, single quotes, and square brackets enclose categories, sub-categories, and spoken contents, respectively.

Ethical concerns

I obtained approval from the participants after explaining that they would participate in this study of their own free will, that the records would be kept safely, and that they would not be used outside the auspices of this study in either oral or written form. The study protocol was approved by the Medical Ethics Committee at Kyoto University.

Results

1. The care recipients' behaviors about which HH felt care difficulties (Table 2)

In all, the HH felt difficulties with 151 distinct behaviors of care recipients ; these were divided into 7 categories and 18 subcategories. The categories "deal with psychiatric symptoms," "deal with depression," "deal with anxiety," "deal with refusal and aggression," "deal with life disabilities," "communication techniques," "action in cases of cognitive impairment," comprised 51, 5, 12, 17, 36, 23, 7, and 17 responses, respectively. The subcategory of "hallucinations and delusions" refers to the tendency to experience auditory hallucinations and soliloquize. "Fluctuations in care recipient's mood" was a subcategory made up of 16 responses describing experiences with fluctuations in the care recipient's behavior among manic-depressive clients. Among descriptions of dealing with hallucinations, "hallucinations in which someone steals" included 12 responses describing the ways in which HH treated care recipients who had hallucinations or negative hallucinations in which they thought responses were stolen by providers of cleaning services. "Behaviors prolonged by symptoms" included 5 responses of sexual problems whereby the care recipient clung to the back of the HH, took off the clothes of the HH, or rendered the HH unable to leave by taking away her bag. "Anxiety about being

Table 2 The ratio of coping levels for HH's coping behaviors

n = 151

categories	subcategories	n	level 1 n (%)	level 2 n (%)	sum of level 1 and level 2 n (%)	level 3 n (%)	level 4 n (%)	sum of level 3 and level 4 n (%)
deal with psychiatric symptoms	hallucinations and delusions	17	16 (94.1)	0	16 (94.1)	0	1 (5.9)	1 (5.9)
	fluctuations in care recipient's mood	16	3 (18.8)	10 (62.5)	13 (81.3)	3 (18.8)	0	3 (18.8)
	hallucinations in which someone steals	12	6 (50.0)	1 (8.3)	7 (58.3)	5 (41.7)	0	5 (41.7)
	behaviors prolonged by symptoms	5	0	0	0	5 (100)	0	5 (100)
	anxiety about being dirty	1	1 (100)	0	1 (100)	0	0	0
subtotal		51	26 (51.1)	11 (21.6)	37 (72.5)	13 (25.5)	1 (2.0)	14 (27.5)
deal with depression	suicidal ideation	2	2 (100)	0	2 (100)	0	0	0
	silence	3	2 (66.7)	1 (33.3)	3 (100)	0	0	0
subtotal		5	4 (80.0)	1 (20.0)	5 (100)	0	0	0
deal with anxiety	anxiety about life	6	0	0	0	1 (16.7)	5 (83.3)	6 (100)
	symptoms of hypochondria	6	1 (16.7)	0	1 (16.7)	5 (83.3)	0	5 (83.3)
subtotal		12	1 (8.3)	0	1 (8.3)	6 (50.0)	5 (41.7)	11 (91.7)
deal with refusal and aggression	treatment refusal and aggression	17	1 (5.9)	14 (82.4)	15 (88.2)	2 (11.8)	0	2 (11.8)
		17	1 (5.9)	14 (82.4)	15 (88.2)	2 (11.8)	0	2 (11.8)
deal with life disabilities	sticking to trivial matters	19	3 (15.8)	12 (63.2)	15 (78.9)	0	4 (21.1)	4 (21.1)
	the rules of life	5	0	5 (100)	5 (100)	0	0	0
	insufficient care time	7	0	0	0	6 (85.7)	1 (14.3)	7 (100)
	no sense of the value of money	1	0	0	0	1 (100)	0	1 (100)
	difficulties understanding life skills	4	0	0	0	0	4 (100)	4 (100)
subtotal		36	3 (8.3)	17 (47.2)	20 (55.6)	7 (19.4)	9 (25.0)	16 (44.4)
communication techniques	how to maintain appropriate distance from care recipients	10	10 (100)	0	10 (100)	0	0	0
	not to hurt care recipient's pride	10	1 (10.0)	1 (10.0)	2 (20.0)	0	8 (80.0)	8 (80.0)
	the proper way to speak to care recipients	3	1 (33.3)	0	1 (33.3)	0	2 (66.7)	2 (66.7)
subtotal		23	12 (52.1)	1 (4.3)	13 (56.5)	0	10 (43.5)	10 (43.5)
action in cases of cognitive impairment	lack of understanding of care service utilization	2	0	0	0	0	2 (100)	2 (100)
	impossibility of physical care or refusal by care recipient	5	0	0	0	5 (100)	0	5 (100)
subtotal		7	0	0	0	5 (71.4)	2 (28.6)	7 (100)
total		151	47 (31.1)	44 (29.1)	91 (60.2)	33 (21.9)	27 (17.9)	60 (39.8)

level 1 : could not treat at all ; level 2 : could not treat ; level 3 : could treat ; level 4 : could treat well

dirty" consisted of a single response describing the difficulties of giving a bath to the care recipient, which was caused by psychiatric symptoms. The "deal with depression" category consisted of 2 responses describing "suicidal ideation" and 3 responses describing "silence"; these described the difficulties when the care recipient complained about a desire to reply, or did not react when, the HH talked to them, respectively. The "deal with anxiety" category consisted of 6 responses describing "anxiety about life" and 6 responses de-

scribing "symptoms of hypochondria," representing dealing with anxiety about living alone and complaints of physical symptoms. "Dealing with refusal and aggression" described instances when the care recipient refused or attacked the HH when the HH tried to provide them with care services : [*The care recipient ordered the HH to do it at once, and the care recipient got angry that the HH touched her ; the care recipient treated the HH harshly, and it upset the HH, but the HH should have understood that the care recipient had*

been sick].

Concerning “deal with life disabilities,” “sticking to trivial matters” was the largest subcategory, with 19 item response describing difficulties whereby HH could not resolve the care recipient’s concern with trivial matters regarding cleaning care services : [*The care recipient’s important things were in the garbage, and the HH did not know that. Consequently, the HH stepped on them, which offended the care recipient. The HH did not understand why the care recipient became stuck on this.*]. “The rules of life” was a subcategory with 5 responses involving rules on cooking and washing, and “insufficiency of care time” had 7 item responses indicating that the HH could not perform the required care services in the time allotted because of the serious nature of the care recipient’s disabilities. “No sense of the value of money” had 1 case in which the HH could not buy the food required to provide cooking services for the care recipient. “Difficulties understanding life skills” comprised 4 item responses, which indicated that the HH could not understand how to impart the skills necessary for care recipients to live independently at home.

“Communication techniques” consisted of several subcategories : “how to maintain an appropriate distance from care recipients” comprised 10 item responses indicating that the HH could not keep an appropriate distance from care recipients, depended on them unnecessarily, or that the relationship between care recipient and HH was broken abruptly. “Not to hurt care recipient’s pride” was a subcategory comprising 10 item responses describing difficulties providing care services that did not hurt the care recipient’s pride. Three item responses described “the proper way to speak to care recipients” and in these situations, the HH did not have adequate opportunities to speak. The “action in cases of cognitive impairment” category consisted of 2 subcategories : 2 items responses described “lack of understanding of care service utilization” and this occurred when care recipients said that the HH service was unnecessary or forgot the home visiting schedule. In addition, “impossibility of physical care or refusal by care recipient” included 5 item responses of situations wherein the HH could not change the diapers or cut the nails of care recipients.

2. The coping of HH

The coping of HH with the various item responses described above was assessed as levels 1–4 for 47 (31.1%), 44 (29.1%), 33 (21.9%), and 27 (17.9%) item responses, respectively. The following are the numbers of item responses for which coping was assessed as levels 3 and 4 : there were 3, 2, 1, 1, 2, 12, 9, 3, 8, 9, 2, 6, and 4 item responses categorized as “consultation with care managers,” “consultation with superior,” “consultation with home visiting nurses” “consultation with staff of day service centers,” “appealing for cooperation with care recipient’s family,” “providing care recipients only with the necessary care,” “comply with care recipient’s pace,” “hear care recipient’s opinion without disagreeing,” “observation of the state of the care recipient’s life,” “inventing methods of care among HH,” “providing care services by a pair of HH,” “actions with care recipients,” and “hear care recipients’ opinions,” respectively.

3. The rates of coping levels according to category and subcategory of difficulties

The categories in which the ratios of levels 1 and 2 coping were over 70% were “deal with psychiatric symptoms,” “deal with depression,” and “deal with refusal and aggression.” Under the category of “deal with psychiatric symptoms,” HH demonstrated levels 2 and 1 coping in 11 (21.6%) and 26 (51.0%) responses, respectively. Under “behaviors prolonged by symptoms,” level 2 or 1 coping was given for 5 responses (100%), and the coping methods were “consultation with care managers,” “consultation with superior,” “consultation with home visiting nurses,” and “care by a pair of HH.” Under the category of “deal with depression,” level 1 coping was given for 4 responses (80.0%), and level 2 coping was given in 1 case (20.0%). In the category “deal with refusal and aggression,” levels 3, 2, and 1 coping were given in 2 (11.8%), 14 (82.4%), and 1 case (5.8%), respectively.

The categories in which the ratios of levels 3 and 4 coping were over 70% were “deal with anxiety” and “action in cases of cognitive impairment.” In “deal with anxiety,” levels 4 and 3 coping were given for 5 (41.7%) and 6 responses (50.0%), respectively ; the coping activities performed were “consultation with care managers,” “consultation with superior,” “comply with care recipient’s

pace,” and “hear the care recipient’s opinion without disagreeing.” In the category of “action in cases of cognitive impairment,” levels 4 and 3 coping were given for 2 (28.6%) and 5 responses (71.4%), respectively. The coping methods used to address these problems were “invention of methods of care among HH” and “actions with care recipients.”

Concerning “deal with life disabilities” and “communication techniques,” the rates of levels 4 and 3 coping were almost equal to those of levels 2 and 1 : levels 1–4 coping were displayed for 3 (8.3%), 17 (47.2%), 7 (19.4%) and 9 (25.0%) responses, respectively.

The summed rates of levels 1 and 2 coping in the subcategories of “sticking to trivial matters” and “the rules of life” were over 70%, but for all categories except for these, the combined rates of levels 4 and 3 coping were 100%.

The coping actions employed were “only provide care recipients with necessary care,” “comply with care recipient’s pace,” “hear the care recipient’s opinion without disagreement,” “observation of the state of care in the recipient’s life,” “invention of methods of care among HH,” “actions with care recipients,” and “hear care recipient’s opinions.”

In the category of “communication techniques,” levels 4, 2, and 1 coping were given for 10 (43.5%), 1 (4.3%), and 12 responses (52.2%), respectively. The coping actions employed were “comply with care recipient’s pace” and “hear the care recipient’s opinion without disagreement.” However, in the subcategories of “how to maintain appropriate distance from care recipients” and “not to hurt care recipient’s pride,” the rates of level 1 coping were 100% and 10%, respectively. The rates of coping levels thus differed according to subcategory.

Discussion

As a result of this investigation of the coping of HH, care recipients’ behaviors with which HH felt care difficulties were classified as either inappropriate behaviors or deal with difficulties. I investigated the relevance of the difficulties felt by HH to their own coping and to care recipients’ behaviors ; the results indicate that support to develop the skills of HH to treat care recipients should be improved.

1. Anxiety caused by a lack of understanding of psychiatric symptoms and complications

The coping levels of HH with respect to psychiatric symptoms such as “hallucinations and delusions,” “sticking to trivial matters,” and “the rules of life” were low and this led to difficulties with care. HH provided by long-term care insurance plans have few opportunities to study and experience care for mental disorders. In cases in which care recipients have psychiatric symptoms, it has been inferred that HH experience anxiety regarding care recipients to “deal with refusal and aggression” and difficulties confirming the intentions of care recipients. If HH could determine the reason for care recipients’ refusals and aggression, they would not be lost as to how to deal with care recipients. The tendency of HH was to hear the care recipients’ talk one-sidedly according to the feelings conveyed by the care recipients’ refusals and aggression. There is a tendency for the emotional relationships between HH and care recipients to have consequences for the provided care¹²⁾ ; if HH could understand care recipients’ symptoms and behaviors, it is possible that their anxiety regarding the provision of care would be ameliorated. Further, it is expected that a training program promoting knowledge and comprehension of psychiatric symptoms among HH would have beneficial effects.

2. Anxiety caused by caring for unstable care recipients

Concerning “deal with psychiatric symptoms,” the levels of coping with “behaviors prolonged by symptoms” were high. As care recipients can continue to live in the community, dealing with “behaviors prolonged by symptoms” is an important issue for care teams providing support to HH. The office manager should decide if care continues to be provided contingent upon the safety of the HH ; therefore, when HH encounter problems of this type, contact should be made with the care manager promptly. As a result, methods that avoid risks—such as emergency correspondence and to provide care services by a pair of HH were adopted by care plans so that coping levels could be increased. However, the possibility that mental health care specialists could estimate the care recipients’ behaviors resulting from prolonged and unstable symptoms is

high. I believe that it is necessary for the care team to discuss emergency correspondence and methods to avoid risks ; therefore, the first care plan should use the start of the introduction of HH care services as its point of reference. The same issues have been raised regarding the issue of unaccompanied home visits by home visiting nurses¹³⁾, so the support of HH (who are not medical personnel) by important teams is required for the effective provision of care services.

Coping levels in the category of “deal with anxiety,” such as behaviors of repeating confirmations, were high, so it seems that factors about which care recipients may become anxious are improved by the exchange of information between care recipients and HH, and care services were devised accordingly. HH consulted and confirmed with home visiting nurses that the care services would be appropriate for the care recipients. Mental health specialists can understand the symptoms of nervous disorders, but these are frequently distorted by care recipients. The coping level with problems of “how to maintain appropriate distance from care recipients” was low, and this leads to the conclusion that HH cannot refuse to comply with contracted care services upon request from the care recipients. As adherence to care plans is contingent upon the stability of the care supply, it is important to improve the systems by which HH can consult with medical staff promptly in case of trouble.

3. Observations of care recipients' lifestyle and care abilities of HH

Concerning “dealing with life disabilities,” HH routinely provided support such as cleaning, shopping, and cooking for care recipients. In order to accomplish this, HH acted in concert with care recipients, observed the state of care recipients' lives, and provided care at care recipient's pace. HH responded to problems caused by cognitive impairments among care recipients through methods such as exchange of information among HH, creating methods to deal with problems, and cooperation with care recipients' families. HH understood to which forms of care recipients would adhere and considered whether the provided care would hurt the care recipients' pride. HH visit care recipients more times than other medical staff and can understand care recipients' conditions easily by

observing their daily living. The abilities of HH to observe the lives of care recipients were high, but inference and assessment were more difficult for them than for nurses¹⁴⁾. With respect to community support for care recipients, it is effective for a multidisciplinary team to jointly hold information on care recipients' daily living in order to perform monitoring of care recipients' treatment. In the future, the role of HH in a multidisciplinary team will become clearer, and collaboration within the team will be effective.

This study consisted of examinations conducted in one area with a small number of participants. It did not clarify the difference in distribution of the coping levels by the participants' characteristics such as age and experience, and did not confirm the validity of the decisions regarding coping levels because I decided the levels according to the descriptions of participants regarding their reasons and feelings ; therefore, the universal validity of deciding the coping levels was not clarified, and it has limited explanatory power. Furthermore, it is necessary to do future studies with more participants and examine the results quantitatively. To settle the issues clarified by this study and reduce the difficulties felt by HH in providing care, it is necessary to construct community support networks and promote training programs to improve the care abilities of HH.

Conclusion

I consider the following 3 points important to address the difficulties that HH feel in providing care :

- 1) To promote training programs to improve the knowledge and comprehension of psychiatric symptoms and disabilities among HH.
- 2) To construct systems whereby HH can consult with medical staff in case of trouble.
- 3) To set up multidisciplinary teams that have joint information regarding care recipients' dialing living situation provided by HH and to monitor care recipients' treatment.

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高齢精神障害者の在宅生活支援において介護職が ケアに困った利用者の行動とその対処

原田小夜^{*,**}

本研究は、高齢精神障害者の在宅生活支援においてホームヘルパー（以下、HH）が対応に困った利用者の行動と HH の対処を検討するためにインタビュー調査を行った。対応に困った利用者の行動を抽出し、カテゴリ分類を試みた。HH の対処を 4 段階のレベル、1「全く対応できなかった」、2「対応できなかった」、3「対応できた」、4「上手く対応できた」に分類し、利用者の行動別に対処レベルの割合を求めた。HH が困った利用者の行動は 151 件で、7 カテゴリ、18 サブカテゴリに分類された。《精神症状への対応》51 件、《うつ状態への対応》5 件、《不安への対応》12 件、《拒否・攻撃への対応》17 件、《生活障害への対応》36 件、《コミュニケーションの取り方》23 件、《認知機能を伴う行為》7 件であった。対処行動は、レベル 1 が 31.1%、レベル 2 が 29.1%、レベル 3 が 21.9%、レベル 4 が 17.9% であった。《精神症状への対応》、《うつ状態への対応》、《拒否・攻撃への対応》が低く、《不安への対応》、《認知機能を伴う行為》で高かった。《生活障害への対応》、《コミュニケーションの取り方》は、サブカテゴリにより異なった。HH のケア困難感を軽減するためには、①精神症状と障害の理解と対処に関する教育プログラムの開発、②ケアチームの医療職に相談できる体制づくり、③ HH の観察情報の多職種ケアチームでの共有とケアモニタリングでの活用の 3 点の重要性が示唆された。

キーワード：高齢精神障害者、ホームヘルパー、対処、ケア困難感

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[Original article]

Effects and Issues in a Coping skill training program for Certified Caregivers

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Aim : To promote comprehensive community care for elderly people with mental and cognitive impairments, the author provided certified caregivers with a care training program to reduce care difficulties and assess the effects and issues.

Methods : The program consisted of a lecture about the features of mental and cognitive functions among elderly people and case studies for dealing with elderly people with mental and cognitive impairments. The author conducted self-rating questionnaires of about 24 items regarding care difficulties before and after the programs. The author used Friedman's test and Bonferroni multiple comparison of analyses for levels of difficulty, and the significance level was $p < 0.05$. regarding care difficulties.

Results : The scores of care difficulties before the training, the average scores were over 3.0 for 7 items and 2.5 for the other items experienced. After the training, the average scores of all of the items experienced were less than 2.0. The levels for the items "understanding mental symptoms and anxiety", "communication techniques" and "deal with refusals" decreased significantly. However, the levels of 4 items "deviating behaviors", "suicidal ideation", "phone calls many times" and "no sense of the value of money" did not decrease. The levels of the item "life disabilities" decreased and participants understood the need for the communication in offices and multidisciplinary collaboration from the case studies.

Conclusion : These programs were effective for certified caregivers to understand mental symptoms and anxiety, to improve communication techniques and dealing with refusals. It is necessary to examine the effects of continuing the training program and the implementation system for the training.

Key words : Aged, Caregiver, Coping skills, Mental disorders, Teaching

Introduction

Japan is a rapidly aging society. A comprehensive

community care system will be constructed by 2025, at which Japanese baby boom generation will become 75years old. The morbidity rate of dementia in people over 65 years has reached over 14%¹⁾, and the coping skills of certified caregivers who have provided the majority of care to those with behavioral and psychological symptoms of dementia (BPSD) are insufficient²⁾. Meanwhile, depression and anxiety patients consult

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psychiatric clinics frequently³⁾, so there are clearly issues regarding home care for elderly people with mental and cognitive impairments. In 2006, a law providing support for the independence of disabled people was enacted and the venues for dealing with mental disorders changed from mental hospitals to the community. However, care services with long-term care insurance have prioritized 'services for people over 65 years old', so that the number of inpatient beds in mental hospitals could be reduced. Certified **caregivers** of long-term care insurance have not been educated about mental diseases and disorders, and they have care difficulties. Consequently, there are few care providers for elderly people with mental disorders.

The author investigated certified caregivers who provide elderly people with the home care called home helper (HH) in Japan regarding the actual care of elderly people with mental disorders, and found that HH had difficulties in dealing with psychiatric **symptoms** and disabilities, but they could not consult any medical professionals if they had trouble. In addition, HH were not confident of giving care to elderly people with mental disorders and wanted to study psychiatric symptoms and disabilities. This strongly suggests the need for training programs for HH⁴⁻⁶⁾.

A comprehensive behavior-management-skills training program for certified nursing assistants who provide care for cognitively impaired nursing home residents reduced the residents' agitation levels⁷⁻¹⁰⁾ while depression training programs and skills training for dealing with people with depression increased among certified caregivers who attended programs that were successfully implemented^{11,12)}.

The fundamental position of Japan's Ministry of Health, Labour and Welfare indicates training systems and programs for the care of dementia patients¹³⁾. However, the effects of these programs have not been clarified, and programs for patients with mental and cognitive impairments without dementia have not been reported. The inception of a law providing **comprehensive** support for disabled people was enacted in 2012. Consequently, seriously disabled people and those with mental disabilities have used home care services, and the services have shifted to community care, so that certified caregivers will play a more important part in

community care. The purpose of this study was to promote comprehensive community care for elderly people with mental and cognitive impairments, so the author offered a training program to certified **caregivers** to reduce care difficulties and assessed the effects and issues.

Methods

Participants

The participants in this study were certified **caregivers** working in community care offices for long-term care insurance in an area with a population of 320,000 and rate a 17.9% elderly population. The author **explained** the purpose of this study to the managers of 12 home care offices to whom the author was introduced by community comprehensive service centers or home visit nursing stations. The author recruited over 50 participants, but home care offices were small, and there were a few offices that had meetings among certified caregivers. Finally, 2 offices consented to the author's proposal. There were 16 people working in the home visiting care offices linked to home visiting nursing stations offices and 23 people working in home visit care and day service care offices link to group homes for people with dementia. Both offices were managed by a social welfare corporation and the managers of the offices were professional care workers who provided care to elderly people with mental disorders and dementia.

Interventions

The program consisted of lectures about the features of mental and cognitive functions among elderly people and case studies for dealing with elderly people with mental and cognitive impairments¹⁴⁻¹⁶⁾. The first time, the author provided a lecture about the behaviors of elderly people with mental and cognitive impairments, and the contents were based on previous research in which home care recipients were perceived by certified caregivers as creating difficulties in terms of care and coping. After 2-3 months, the author provided a second program with a review of the first lecture and case studies were provided by participants. The program lasted one to one and half hours, and the author **provided** it three times; two groups consisted of 8 members and one group consisted of 23 members. The program

was carried out from August to October 2012.

Data collection

The author administered self-rating questionnaires survey to participants three times as follows : before and after the first training and after the second training. The author distributed and collected the self-rating questionnaires to participants directly at the time of training. The author asked participants to write code numbers for personal identification. The author collected data regarding age, sex, number of **experiences** of care for recipients with mental and cognitive function disorders ; schizophrenia, depression, home care or day service, care difficulties, impression about the programs, and free description. There were 24 items about “care difficulties” grouped as follows : dealing with psychiatric symptoms, depression, anxiety, refusal and aggression, communication skills, and dealing with cognitive impairments, which the author referred to in previous research⁶⁾. The Likert scale of feeling care difficulties (*can handle well, can handle without feeling difficulties, can handle but feel difficulties, and cannot handle and feel difficulties*) were assigned from levels 1–4, respectively.

Analysis

The author measured the ratios of the participants’ characteristics, experiences and feeling of difficulty levels of the 24 items. The author used Friedman’s test and Bonferroni multiple comparison of analyses for levels of difficulties as follows ; before and after first training, and after second training. IBM SPSS Statistics (Statistical Package for Social Sciences ver. 20 for Windows) was used for the statistical analyses, and the significance level was $p < 0.05$. Regarding feeling of difficulty, authors processed data excluding missing values for every feeling of difficulty level item.

The author classified free descriptions into categories according to the contents of participants’ comments on care and coping. In the following sections, double quotes, single quotes, and square brackets enclose categories, subcategories, and spoken contents, **respectively**.

Ethical concerns

The author obtained approval from the participants after explaining that they would participate in this study of their own free will, that the records would be

kept safely, and that they would not be used outside the auspices of this study in either oral or written form. The study protocol was approved by the Medical Ethics Committee at Kyoto University.

Results

1. The characteristics and experiences of the participants’ care

The participants comprised 2 male and 37 female individuals, and they were aged 47.0 ± 9.4 ; eight participants were regular workers employed full-time and 31 participants were part time workers. Their average number of years of experience as certified caregivers was 5.82 and the range was 1.2 to 13 years. The rates of participants who attended the training with dementia and mental disorders were 35.9% and 10.3%, respectively. The rates for giving care to patients with mental and cognitive function disorders, schizophrenia, depression, and others, were 46.2%, 12.8%, 30.8% and 20.5%, respectively (**Table 1**).

Regarding having had experience of the 24 items, over 80% of items had been experienced by 83.4% and 82.0%, (2 and 12 caregivers, respectively). Experience rates over 60% included 66.7% and 64.1% of caregivers, (15 and 22 caregivers, respectively). Experience rates over 50% were experienced by 59.0% and 53.8%, (10 and 1 caregivers, respectively). Items at low rate were experienced by 7.7%, 10.0%, 10.0%, 12.8%, 23.1% and 25.7%, and rates of 11, 5, 7, 19, 8, 4 and 24, respectively (**Table 2**).

2. The scores for feeling care difficulties (**Table 3**)

1) The scores for feeling care difficulties before the training

Items with average scores over 3.0 were experienced by 3.31 ± 0.74 , 3.16 ± 0.83 , 3.12 ± 0.90 , 3.07 ± 1.23 , 3.06 ± 0.61 , 3.03 ± 0.77 and 3.00 ± 1.35 , with average scores of 15, 24, 14, 8, 2, 7 and 5, respectively. The average scores were over 2.5 for the other items experienced.

2) The scores of feeling care difficulties after the training

The average scores of all of the items experienced were less than 2.0. Items experienced with significant results between the score before the training and after training included 19 items as follows ; 1, 2, 3, 6, 7, 9, 10, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24. The items

Table 1 Characteristics of the participants

		N=39	
	Categories	n (%)	
Sex	Male	2	(5.1)
	Female	37	(94.9)
Employment	Regular workers	8	(20.5)
	Part time workers	31	(79.5)
License	Professional care worker	14	(35.9)
	Home helpers	25	(64.1)
Attended the training programs	Mental disorders	Yes	4 (10.3)
		No	35 (89.7)
	Dementia	Yes	25 (64.1)
		No	14 (35.9)
	Mental and Cognitive functions	Yes	18 (46.2)
		No	21 (53.8)
Care experiences	Schizophrenia	Yes	5 (12.8)
		No	34 (87.2)
	Depression	Yes	12 (30.8)
		No	27 (69.2)
	Other mental disease	Yes	8 (20.5)
		No	31 (79.5)

with average scores which were 1.9–1.0 after the second training were 1.68 ± 0.49 , 1.87 ± 0.68 , 1.86 ± 0.66 , 1.88 ± 0.53 , 1.93 ± 0.46 , 1.95 ± 0.76 , 1.96 ± 0.71 and 1.97 ± 0.62 , with average scores of 16, 17, 9, 10, 22, 6, 21 and 12, respectively. Regarding item 16, between the score before the training and the score after the first training did not differ significantly, but the score after the second training was significantly. Regarding the items which were not significant between the scores before and after, the before training scores and after second training scores were 2.27 ± 1.08 and 2.22 ± 0.88 , 3.00 ± 1.35 and 2.36 ± 0.92 , 3.07 ± 1.23 and 2.60 ± 0.28 , 2.67 ± 1.17 and 2.20 ± 0.68 and 2.54 ± 1.13 and 2.31 ± 0.63 , with scores of 4, 5, 8, 11 and 19, respectively. There were no items experienced that were significant between the score after the first training and the score after the second training.

3. The contents of the free descriptions

1) The contents of the free descriptions after the first training

There were 21 descriptions, and “respecting the recipient’s feelings” was experienced by 8 : *[It was important that certified caregivers sympathize with care*

recipients]. “Viewpoint on the care” was experienced by 5 : *[Certified caregivers would not provide care services inside their framework]*. “Communication and care techniques” was experienced by 8 *[It is important that certified caregivers adjust to the recipients]* and *[attitude of waiting for the recipients to answer without certified caregivers decide]*. A desire to study schizophrenia because of a lack of skills was experienced by 2.

2) The contents of the free descriptions after the second training

There were 54 free descriptions; these were divided into 2 categories as “certified caregivers’ care skills” and “exchange information and collaboration”. “Certified caregivers’ care skills” consisted of ‘respecting the recipient’s feelings’, ‘communication and care techniques’ and ‘understanding the disease’. “Exchange information and collaboration” consisted of ‘exchange information and case studies in the office’, ‘multidisciplinary collaboration’ and ‘collaboration with families’. Regarding after the second training, “exchange information and case studies in the office” were experienced as *[the subjects have jointly shared recipient’s informa-*

Table 2 Participants' experience for items of care difficulties

N=39

	Yes n (%)	No n (%)	NA n (%)
1. Hallucinations and delusions	21 (53.8)	17 (43.6)	1 (2.6)
2. Fluctuations in care recipient's mood	33 (84.6)	6 (15.4)	
3. Hallucinations in which someone steals	17 (43.6)	21 (53.8)	1 (2.6)
4. Sexual behaviors	9 (23.1)	30 (76.9)	
5. Threatened by care recipients	4 (10.0)	35 (90.0)	
6. Causing care recipients anxiety about being dirty	14 (35.9)	24 (61.5)	1 (2.6)
7. Speaking about suicide	26 (66.7)	12 (30.7)	1 (2.6)
8. Suicidal ideation	5 (12.8)	34 (87.2)	
9. Care recipients not speaking and being silent	18 (46.1)	20 (51.3)	1 (2.6)
10. Speaking of anxiety about life	23 (59.0)	16 (41.0)	
11. Phone calls many times	3 (7.7)	36 (92.3)	
12. Symptoms of hypochondria	32 (82.0)	6 (15.4)	1 (2.6)
13. Certified caregivers scolded by care recipients, but not understanding why	13 (33.3)	26 (66.7)	
14. Care recipient's violence	17 (43.6)	22 (56.4)	
15. Refusal of care that certified caregivers could not understand	25 (64.1)	13 (33.3)	1 (2.6)
16. Care recipients cannot dump trash	11 (28.2)	27 (69.2)	1 (2.6)
17. Rules of life	18 (46.1)	19 (48.7)	2 (5.2)
18. Insufficient care time	16 (41.0)	21 (53.8)	2 (5.2)
19. No sense of the value of money	4 (10.0)	35 (90.0)	
20. Difficulties understanding life skills	19 (48.7)	18 (46.1)	2 (5.2)
21. How to maintain appropriate distance from care recipients	17 (43.6)	19 (48.7)	3 (7.7)
22. Not to hurt care recipient's pride	25 (64.1)	13 (33.3)	1 (2.6)
23. Proper way to speak to care recipients	16 (41.0)	20 (51.2)	3 (7.7)
24. Care recipients forget when certified caregivers will visit	10 (25.7)	25 (64.3)	4 (10.0)

tion and had care conferences about each recipient] and [the subjects have to understand the recipient's needs by exchanging information in the care team]. And 'collaboration with families' was experienced as [collaboration with the recipient's families and need the opportunities of hearing family's mind of the recipient's care].

Discussion

1. Concerning the items for which the levels difficulty were reduced

The average scores of the care items with respect to understanding psychiatric symptoms and anxieties, communication techniques, and dealing with refusal and aggression decreased. Thesis items were characterized as to whether certified caregivers could change how to deal with recipients' behaviors if they received

acknowledgment and understand the recipient's mentality. The certified caregivers could cope with a made-up story and delusions, they could comprehend which recipients had anxieties and deal with delusions. They could put techniques studied in the training programs into practice such as not to disagree and assess the delusions. The certified caregivers had ambivalent feelings. They wanted to provide care and listen carefully to the recipient's comments and provide care that answered the recipients' many complaints. Certified caregivers tried to talk to the recipients without interrupting the conversations when they felt difficulties in communication such as refusals and silence⁵⁾. Certified caregivers could not conceal their irritation when dealing with recipients and got irritated if they could not provide the level care services they

Table 3 The levels of items before the training, after the first time and the second time

		Mean	SD	χ^2 -score	<i>P-value</i>	Multiple comparison <i>P-value</i>	
1. Hallucinations and delusions (n=28)	before	2.54	.51	14.03	.001]	*
	first	1.96	.79				
	second	2.00	.67				
2. Fluctuations in care recipient's mood (n=33)	before	3.06	.61	32.11	.000]	**
	first	2.15	.71				
	second	2.24	.61				
3. Hallucinations in which someone steals (n=23)	before	2.91	.85	20.03	.000]	**
	first	2.04	.77				
	second	2.17	.72				
4. Sexual behaviors (n=18)	before	2.27	1.07	4.79	.091		
	first	2.50	1.15				
	second	2.22	.88				
5. Threatened by care recipients (n=11)	before	3.00	1.34	4.46	.108		
	first	2.36	.92				
	second	2.36	.92				
6. Causing care recipients anxiety about being dirty (n=20)	before	2.75	.97	14.38	.001]	*
	first	1.75	.64				
	second	1.95	.76				
7. Speaking about suicide (n=30)	before	3.03	.77	22.63	.000]	**
	first	2.23	.77				
	second	2.13	.82				
8. Suicidal ideation (n=15)	before	3.07	1.28	5.09	.078		
	first	2.60	.99				
	second	2.60	.28				
9. Care recipients not speaking and being silent (n=21)	before	2.86	.79	16.09	.000]	**
	first	1.95	.92				
	second	1.86	.66				
10. Speaking of anxiety about life (n=25)	before	2.64	.91	11.76	.003]	*
	first	1.84	.69				
	second	1.88	.53				
11. Phone calls many times (n=15)	before	2.67	1.18	3.54	.171		
	first	2.20	.94				
	second	2.20	.68				
12. Symptoms of hypochondria (n=30)	before	2.83	.70	30.78	.000]	**
	first	1.87	.57				
	second	1.97	.62				

Table 3-2 The levels of items before the training, after the first time and the second time

		Mean	SD	χ^2 -score	<i>P-value</i>	Multiple comparison <i>P-value</i>	
13. Certified caregivers scolded by care recipients, but not understanding why (n=19)	before	2.74	.93	6.93	.031		
	first	2.11	.94				
	second	2.26	.73				
14. Care recipient's violence (n=24)	before	3.12	.90	7.41	.025		
	first	2.54	.83				
	second	2.71	.87				
15. Refusal of care that certified caregivers could not understand (n=26)	before	3.31	.74	20.73	.000]**]**
	first	2.42	.76				
	second	2.42	.81				
16. Care recipients cannot dump trash (n=19)	before	2.63	1.01	11.70	.003]**
	first	1.95	.78				
	second	1.68	.48				
17. Rules of life (n=24)	before	2.67	.82	23.75	.000]**]**
	first	1.79	.59				
	second	1.87	.68				
18. Insufficient care time (n=23)	before	2.96	.83	13.09	.001]**]**
	first	2.35	.78				
	second	2.26	.73				
19. No sense of the value of money (n=13)	before	2.54	1.13	1.31	.519		
	first	2.15	.80				
	second	2.31	.63				
20. Difficulties understanding life skills (n=22)	before	2.77	.87	8.95	.011		
	first	2.23	.75				
	second	2.23	.61				
21. How to maintain appropriate distance from care recipients (n=23)	before	2.57	.90	8.81	.012		
	first	1.96	.64				
	second	1.96	.71				
22. Not to hurt care recipient's pride (n=29)	before	2.72	.59	26.44	.000]**]**
	first	1.86	.69				
	second	1.93	.46				
23. Proper way to speak to care recipients (n=20)	before	2.65	.88	7.97	.019		
	first	2.00	.80				
	second	2.05	.61				
24. Care recipients forget when certified caregivers will visit (n=19)	before	3.16	.83	13.56	.001]**	
	first	2.11	.66				
	second	2.21	.86				

before : before the training, first : after the first time, second ; after the second time

The Likert scale of feeling care difficulties (can handle well, can handle without feeling difficulties, can handle but feel difficulties, and cannot handle and feel difficulties) were assigned from levels 1-4

Friedman's test, df=2, Bonferroni multiple comparison : significant at **p<0.01, *p<0.05

hoped¹⁸⁾. Consequently, in the training the author assured them there were occasions when certified caregivers could not provide the care service according to the care plan and educated them that their impatience and anxiety could influence the recipients' mental state. The difficulties in communication with the care recipient among participants decreased based on descriptions such as *[the subjects became composed by providing care services]* and *[the subjects could deal with the recipient by thinking about the reasons for behaviors]*. The certified caregivers differed from mental medical staff in that they could not study mental and cognitive impairments systematically and consider the recipient's behavior from different angles. As a result, they tended to stick to the diagnosis. They also had care difficulties because many recipients did not have a clear diagnosis, so that they could not utilize education about diseases and disabilities. Therefore, the certified caregivers could study features of mental and cognitive functions among elderly people by relating to the recipient's behaviors that make it difficult to cope, so these training programs were effective.

2. Items for which level of difficulty were not reduced

The items "sexual behaviors", "threatened by the recipients", "suicidal ideation", "phone calls many times" and "no sense of the value of money" did not improve. The rates of these items that participants experienced were low. Concerning deviating behaviors such as "sexual behaviors", "threatened by the recipients" and "suicidal ideation", it was difficult to cope with these behaviors for certified caregivers unless they study the mental diseases and mental and cognitive impairments. The author did not specifically educate caregivers to cope in this training program. In a study of collaborations between home helpers and mental medical staff for adults with mental disorders, it was necessary for collaborations by emergency correspondence when the deviating behaviors and suicidal ideation appeared to worsen¹⁹⁾. These items were necessary to consider how to deal with individual recipients, and the levels of difficulty were not reduced significantly. "Phone calls many times" and "no sense of the value of money" were not emergencies, but these difficult issues could be settled by comprehension of the symptoms, disabilities and background to the

recipient's behaviors. Therefore, it is necessary to deal with individual recipients by exchanging information in offices and collaborations in a multidisciplinary way to improve these items.

3. Items needed for case studies education

The certified caregivers could understand mental and cognitive function and disabilities ; they had questions about the aim of the care and their role that medical staff indicated. As a result, the author introduced case studies at the participants request in the second training, and there were a lot of descriptions about exchanging information and collaboration after the second training. Before this training program, participants in offices had few opportunities to exchange information and case studies. The person in charge of long-term insurance attended a care conference about care services, but the certified caregivers did not attend any care conferences. Therefore, the author wondered that even if certified caregivers had knowledge about mental and cognitive functions and disabilities, they would not be able to contact or consult anyone about the knowledge. The case studies in the second training provided studies both about how to provide care services and opportunities that they thought necessary for exchanging information and multidisciplinary collaboration. The author recommend that it is necessary that certified caregivers have full access to case studies in the office, so that the care skills for recipients' disabilities and the recognition of collaboration with staff in the office and multidisciplinary collaboration can improve.

4. Issues regarding the training program

The rate of experience of the care for mental disorders was low, but caregivers provided dementia recipients care services at all times, and they must provide care services for the recipients with mental and cognitive impairments such as BPSD. Therefore, it is necessary that the author educate certified caregivers to deal with recipients to prevent them from developing BPSD after this program. In foreign countries, the study of individual study programs of dementia by using internet services has advanced²⁰⁾. The dementia care research and training center in Japan ran a training program about DCM : Dementia Care Mapping and the fundamental position of Japan's

Ministry of Health, Labour and Welfare has indicated training programs in the practice of care for dementia patients. The people who attended the programs gave feedback and played a leading part in offices. The author provided training programs as follows ; participants in two offices, small group size, in the participant's office, when the staff can attend, so that all of staff can attend the common program and case studies, most of the staff felt it necessary to study together for effective programs. Home care offices are administered by only a few full-time staff and employ mostly part-time staff, and it is necessary to consider the implementation of training programs. Furthermore, the author need to do follow-up training programs and see if participants remember the knowledge and skills to deal with recipients because some items showed improved levels after second training.

This study consisted of examinations conducted in one area with a small number of participants. It did not clarify the difference in distribution of the levels of difficulty by the participants' characteristics such as age and experience, and the self-rating questionnaires the author used this study did not confirm the reliability and validity ; therefore, the universal validity for deciding the levels was not clarified, indicating limited explanatory power. The author need to examine the evaluations by the recipients and families about the care services received from the caregivers who accepted the training program. Furthermore, it is necessary to do future studies with more participants and examine the results quantitatively. To settle the issues clarified by this study and reduce the difficulties felt by certified caregivers in providing care, it is necessary to construct multidisciplinary collaboration and community support networks.

Conclusion

These training programs educated caregivers about mental and cognitive functions among elderly people by connecting with difficult recipient behaviors and participants took an active part in the program. The author considers the effects and issues as follows : The levels of items for 'understanding mental symptoms and anxiety', 'communication techniques' and 'deal with refusals' were reduced significantly. Although the

levels of the items that dealt with 'deviating behaviors', 'suicidal ideation', 'phone calls many times' and 'no sense of the value of money' were not reduced. The levels of the items that dealt with life disabilities were reduced and participants understood the necessity for the communication in offices and multidisciplinary collaboration using case studies. It is necessary to examine the continuation of effects of the training program and methods for administering training system.

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介護職の対処能力向上プログラムの効果と課題

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精神認知機能に問題がある高齢者の地域包括ケアを進めるために、介護職のケア困難感を軽減することを目的に教育プログラムを提供し、その効果と課題を検証した。プログラムは、高齢者の精神認知機能の特徴、精神認知機能の問題への対応に関する講義と事例検討である。研修前後に自記式アンケートを実施した。困難度 24 項目のリッカートスケールを作成し、研修前後の得点の比較について Friedman 検定を実施し、困難度に違いが見られた項目について多重比較（Bonferroni の調整）を行った。有意水準は 5% とした。研修前の困難度では、7 項目が 3.0 以上、その他でも 2.0 以下の項目は無かった。精神症状、不安に対する理解、コミュニケーションの取り方、ケアの拒否の項目は、研修後に困難度が有意に減少した。逸脱行動、自殺企図、頻回の電話、金銭感覚など利用者に応じた具体的な対応の必要がある項目の困難度は変わらなかった。事例検討によって、生活障害に対する困難度の軽減が図れ、事業所内の情報交換や多職種連携の必要性の理解に繋がった。

キーワード：高齢者、介護職、対処技能、精神障害、教育プログラム

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